

International Braz J Urol

EDITOR'S COMMENT

The May – June 2003 issue of the International Braz J Urol presents interesting contributions from different countries, and as always the Editor will highlight some important papers.

Doctors Marcovith and Smith from Long Island Jewish Medical Center, New Hyde Park, New York, USA, provided on page 195 a thorough presentation and discussion on how to choose extracorporeal shock wave lithotripsy (SWL) and percutaneous nephrolithotomy (PNL) for treating renal pelvic stones. The authors stated that the most important to consider is that there is a rational approach to the selection of SWL or PNL. Each modality has advantages and disadvantages, and the application of either one should be based on well-defined factors. These variables include stone factors such as number, size, and composition; factors related to the stone's environment, including the stone's location, spatial anatomy of the renal collecting system, presence of hydronephrosis, and other anatomic variables, such as the presence of calyceal diverticula and renal anomalies; and clinical or patient factors like morbid obesity, the presence of a solitary kidney, and renal insufficiency. The morbidity of each procedure in relation to its efficacy should be taken into account. This article synthesized the current knowledge, and provided guidelines that represent state-of-the-art recommendations for treatment of stones of the renal pelvis using these 2 modalities.

Doctor Prando from Vera Cruz Hospital, Campinas, São Paulo, Brazil, proposed on page 208 a radiological classification of renal angiomyolipomas after studying an important series of 127 tumors. The author, based on the presence and amount of identifiable fat within the lesion, classified the renal angiomyolipomas in 4 distinct radiological patterns: pattern-I, predominantly fatty (usually less than 2 cm in diameter and intrarenal), corresponding to 54% of the cases; pattern-II, partially fatty (intrarenal or exophytic = 29%); pattern-III, minimally fatty (most exophytic and perirenal = 11%); and pattern-IV, without fat (most exophytic and perirenal = 6%). This classification would have important implications for management and selection of therapeutic alternatives. Doctor Rosenfield from Yale University School of Medicine, New Haven, Connecticut, USA, provided an excellent Editorial Comment on this manuscript.

Doctors Dall'Oglio and colleagues, from Federal University of São Paulo, Brazil, analyzed on page 221 the evolution of 5 cases of disruption of vesicourethral anastomosis during the post-operative period in a consecutive series of 1,600 radical retropubic prostatectomies, performed by a single surgeon. The management was conservative in all the cases with an average catheter permanence of 28 days. Two cases were secondary to bleeding, 1 followed the change of vesical catheter

and 2 were by unknown causes after removing the Foley catheter. Only one patient evolved with urethral stenosis, in the period ranging from 6 to 120 months. The authors concluded that this rare complication (0.3%) is not related to the surgeon's experience, and conservative treatment has shown to be effective.

Doctors Suaid and co-workers from University of São Paulo, Brazil, estimated the costs of benign prostatic hyperplasia (BPH) treatment in Brazil (page 234). The authors found that the estimated population for medical treatment was 5,397,321 individuals, with a cost corresponding to US\$ 1,916,489,055.00. The estimated population for surgical treatment was 2,040,299 men, what would represent a cost of US\$ 353,291,204.00 based on the Brazilian Unified Health System table and of US\$ 1,904,279,066.00 based on the Brazilian Medical Society table, with hospital expenses included. These figures induce us to predict that the treatment of BPH in the near future can become a public health problem for Brazilian society, since the current estimate costs would be around 2.26 – 3.83 billion dollars, added by the yearly increase in the risk population (25%) for the group under medical treatment and over the non-operated amount of the surgical group.

Doctors Rubeinstein and McVary, from Northwestern University, Chicago, Illinois, USA, in the best of my knowledge, provided our readers with the most complete and up-to-date presentation on transurethral microwave thermotherapy (TUMT) for benign prostatic hyperplasia (BPH) available in the literature (page 251). In this review, the authors discussed the current indications and outcome of TUMT, including the history of the procedure, the mechanism of action, the indications for TUMT, the pre-operative considerations, the patient selection, the results in terms of efficacy, by comparing TUMT vs. Sham, TUMT vs. Alpha-blocker and TUMT vs. TURP. Finally, the complications are presented, as well as other uses and future directions of the procedure. The authors concluded that TUMT is a safe and effective minimally invasive alternative to treatment of symptomatic BPH. Since TUMT can be performed in a 1- to 2-hour office visit without intravenous sedation, this is a good alternative for patients who are at high surgical and anesthetic risk. Nevertheless, the procedure is not effective for patients with a large median lobe or a very large prostate and results in less urinary flow patterns than transurethral resection of the prostate.

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Editor-in-Chief